

**Request for Home and Community Care Support Services
Hamilton Niagara Haldimand Brant**

Patient Name _____ HCN _____ VC _____ DOB _____		
Address _____ City _____ Province _____ Postal Code _____		
Patient Phone _____ Contact Name _____ Contact Phone _____		
<input type="checkbox"/> Community: Fax completed form to 1-866-655-6402 <input type="checkbox"/> Hospital: Fax completed form to hospital HCCSS HNHB office (see pg. 2); Hospital Referrals: Unit/floor _____ Planned Hospital Discharge Date _____ <input type="checkbox"/> Bundle Holder Referral for Service – Hospital Site _____ Bundle Type _____		
<input type="checkbox"/> The patient or lawfully authorized substitute decision maker has consented to this referral <input type="checkbox"/> Please contact the person below (rather than the patient) for assessment, due to: <input type="checkbox"/> Patient Preference <input type="checkbox"/> Hearing Difficulties <input type="checkbox"/> Cognitive Status <input type="checkbox"/> Language Difficulties <input type="checkbox"/> Other _____		
Contact Person _____ Relationship _____		
Phone (Home) _____ Phone (Cell) _____ Phone (Work) _____		
Primary Care Physician _____ Phone _____		
Primary Diagnosis _____ Date _____		
Secondary Diagnosis _____ Diagnosis Discussed With Patient <input type="checkbox"/> Yes <input type="checkbox"/> No With Family <input type="checkbox"/> Yes <input type="checkbox"/> No		
Prognosis <input type="checkbox"/> Improved <input type="checkbox"/> Remain Stable <input type="checkbox"/> Deterioration Prognosis Discussed With Patient <input type="checkbox"/> Yes <input type="checkbox"/> No With Family <input type="checkbox"/> Yes <input type="checkbox"/> No		
Surgical Procedure _____ Date _____		
Current Medications <input type="checkbox"/> Medication List Attached <input type="checkbox"/> Health Profile Attached WSIB Claim <input type="checkbox"/> Yes <input type="checkbox"/> No		
Allergies _____ Special Diet _____		
Wound Care (Include location) _____ <i>Note: If not specified, nurse will assess and provide recommendations. Wound care products may be substituted to a comparable product based on HNHB supply list.</i>		
Weight Bearing <input type="checkbox"/> Full <input type="checkbox"/> Partial <input type="checkbox"/> Feather <input type="checkbox"/> None Activities Permitted _____		
Completion of additional forms are required for the following protocols (select link to open form): Central Vascular Devices Vancomycin & Aminoglycoside Prescriptions Protocol for First Dose IV		
<input type="checkbox"/> Activities of Daily Living	<input type="checkbox"/> Behavioural Supports (e.g. BSO)	<input type="checkbox"/> Chronic Disease Management
<input type="checkbox"/> Community Support Services/ Resources	<input type="checkbox"/> Dementia/ Memory Impairment	<input type="checkbox"/> Health Link Patient
<input type="checkbox"/> Home Safety	<input type="checkbox"/> Housing Options	<input type="checkbox"/> Medication Management
<input type="checkbox"/> Mobility/ Risk of Falls	<input type="checkbox"/> Pain Management	<input type="checkbox"/> Palliative Care/ End of Life - PPS% _____
<input type="checkbox"/> Social Isolation	<input type="checkbox"/> Strengthening	<input type="checkbox"/> Speech Language Pathology
Medical Orders: <input type="checkbox"/> Same Day Request <input type="checkbox"/> Additional information attached. Total Number of Pages _____		
<input type="checkbox"/> Indwelling Urinary Catheter Care: Insertion Date: _____ Size: _____ Type: _____ Standard maintenance for Indwelling or Suprapubic Catheter: Change latex catheter monthly and PRN, Change silastic and silicone – silicone coated catheters every 3 months and PRN. Irrigate catheter with 50-100 mL Normal Saline PRN. <i>Note: if size/type not specified, standard foley catheter kit will be provided with #14 & 16 silicone coated catheter for nurse to use discretion</i>		
Thank you for your referral. The Home and Community Care Support Services Hamilton Niagara Haldimand Brant will assess and work with your patient to develop a care plan that includes service location, frequency and health teaching to support independence. For questions please call 1 800 810 000 from 8:30 am to 8:30 pm, 7 days a week.		
Name _____ <input type="checkbox"/> MD <input type="checkbox"/> NP Telephone _____ <small>(Please Print)</small>		
Signature _____ Date _____ CPSO/CNO Reg. # _____		

**Home and Community Care Support Services
Hamilton Niagara Haldimand Brant
FAX Numbers**

All Community Referrals including Primary Care Providers please FAX Page 1 of this Form to:

HCCSS HNHB Intake & Extended Hours	1-866-655-6402
------------------------------------	----------------

For Hospital-based referrals please FAX Page 1 of this form directly to the appropriate HCCSS HNHB Hospital Office:

Brantford

Brantford General	519-752-2186
-------------------	--------------

Burlington

Joseph Brant Hospital	905-637-7668
-----------------------	--------------

Haldimand-Norfolk

Haldimand War Memorial Hospital	519-426-8410	Norfolk General Hospital	519-426-8410
West Haldimand General Hospital	519-426-8410		

Hamilton

Hamilton General Hospital	905-527-8094	St. Joseph's Hospital, Charlton Site	905-522-2057
Juravinski Cancer Centre	905-575-6311	St. Joseph's Hospital, Mountain Site	905-388-9141
Juravinski Hospital	905-387-4450	St. Peter's Hospital	905-549-8564
McMaster University Medical Centre	905-529-2291		

Niagara

Douglas Memorial Hospital	905-991-0697	St. Catharine's General Hospital	905-323-9763
Greater Niagara General Hospital	905-374-1028	St. Catharine's General Hospital ED	905-704-4766
Greater Niagara General Hospital ED	905-374-1028	Welland County Hospital	905-732-0098
Hotel Dieu Shaver – Rehab Centre	905-685-0642	Welland County Hospital ED	905-732-9753
Port Colborne General Hospital	905-835-9404	West Lincoln Memorial Hospital	905-309-8576